MDR Tracking Number: M2-03-1305-01
IRO Certificate# 5259

July 1, 2003

An independent review of the above-referenced case has been completed by a medical physician [board certified] in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
There is no clinical history presented reflecting the original mechanism of injury, the initial diagnosis, the initial physical findings, or response to treatment. There is a denial on pre-authorization for the purchase of this device; there is a vendor generator form that supposedly represents a physician prescription, a boilerplate letter of medical necessity and a device generated progress report. It should be noted that between the initial report date of February 18 and the subsequent report date of May 5, there has not been any improvement in the condition of this patient. Muscle spasms are noted "most of the time", limited movement went from most of the time to all of the time; and the leading questions clearly received the answers intended. The utilization graph noted four and five day gaps when the device was not being used.

REQUESTED SERVICE (S)
Purchase of Interferential stimulator

DECISION
Uphold denial- endorse the determination made by the pre-authorization reviewer.

RATIONALE/BASIS FOR DECISION
The primary treating physician failed to produce any competent, objective, and independently confirmable medical evidence demonstrating the efficacy of this device. The use is sporadic and there is no measurable improvement in this condition. Has the use of oral analgesic been reduced? There is no data to indicate that is the case. Why would this claimant go for days without using the device if it were so desperately needed? And then after not using the device for several days, only one 15-minute session was noted. Clearly there is no established positive result from the use of this device.

Moreover, there is no clinical assessment made by the primary treating physician that would support the use, let alone the purchase, of this device. Lastly, this is a passive device and noting the date of injury, this claimant should be doing only those active modalities that enhance the rehabilitation of this injury.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©)

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3)

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 2nd day of July 2003.